8-1-2003

Barriers to Communication in Healthcare: Perceptions of the Rural Elderly

Nicole Arachikavitz
Western Kentucky University

BARRIERS TO COMMUNICATION IN HEALTHCARE: PERCEPTIONS OF THE RURAL ELDERLY

A Thesis
Presented to
The Faculty of the Department of Public Health
Western Kentucky University
Bowling Green, Kentucky

In Partial Fulfillment
Of the Requirements for the Degree
Master of Public Health

By
Nicole Arachikavitz

August 2003

BARRIERS TO COMMUNICATION IN HEALTHCARE:
PERCEPTIONS OF THE RURAL ELDERLY

Date Recommended 8-13-03

Director of Thesis

Dean, Graduate Studies and Research, Date 9/05/03

ACKNOWLEDGMENTS

The author wishes to express sincere appreciation to Professors Gardner, Lindley, and Wilson for their assistance in the preparation of this manuscript. In addition, special thanks to the director of Community Action, Sandi Knight, and each of the directors of the BRADD Senior Centers who allowed me to visit the centers and interview the rural elderly.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS iii

LIST OF FIGURES vi

ABSTRACT vii

CHAPTER

1 INTRODUCTION 1
Definitions 3

CHAPTER

2 REVIEW OF LITERATURE 4
Rural Elderly 4
Barriers to Communication 8

CHAPTER

3 METHODOLOGY 18
Research Question 18
Population 18
Eligibility Criteria 19
Participant Recruitment 19
Data Collection 20
Measures 20
Data Analysis 24

CHAPTER

4 RESULTS 25
Demographic Characteristics 25
Health Related Information 25
Barriers to Communication 26
Open-Ended Questions 28

CHAPTER

5 DISCUSSION 30
What Types of Communication Barriers do Rural Elderly Face When Seeking Healthcare? 30
Limitations 33
Future Studies 35
Conclusions 35

REFERENCES 37

APPENDICES

A CONSENT FORM 40

B INTERVIEW GUIDE 42

C TABLES 45
1. Distributions of the Demographic Characteristics of the Respondents 45
2. Distributions of the Health-Related Information of the Respondents 47
3. Distributions of the Barriers to Communication Faced by Rural Elderly 48

LIST OF FIGURES

Figure		Page
1	Percent Distribution of the Elderly in Rural Areas by Age Group	5
2	Percent Distribution of the Elderly in Rural Barren River Area Development District (BRADD) Counties	6
3	Educational Attainment of Citizens of Rural Counties in BRADD	7
4	Percent of the Elderly Considered Poor in BRADD Counties	8
5	Distribution of Participants Recruited from Each County	19

BARRIERS TO COMMUNICATION IN HEALTHCARE:
PERCEPTIONS OF THE RURAL ELDERLY

Nicole Arachikavitz August 2003 50 pages

Directed by: Marilyn Gardner, Lisa Lindley, Richard Wilson

Department of Public Health Western Kentucky University

There is presently a lack of research on the types of communication barriers faced by the rural elderly when accessing health care. Furthermore, much of the research on the rural elderly is old and outdated. Thus, this thesis research sought to identify and explore communication barriers faced by the rural elderly when accessing healthcare. Specifically, the research in this thesis seeks to answer the following research questions: What types of communication barriers do rural elderly face when seeking health care? More specifically, what sorts of patient-provider communication barriers will the rural elderly of South Central Kentucky identify? An interview guide was developed to explore the perceived communication barriers encountered when accessing healthcare. The data were collected from subjects, who must have been at least 65 years of age and must have visited a senior center in the Barren River Area Development District on the date of interviews (n=59). The data was analyzed using frequencies and central tendencies with SPSS. The study satisfied the purpose of expanding and updating what is known about the communication barriers faced by the rural elderly when accessing health care. The study also demonstrates that further research is needed on this topic to update the current knowledge even more so.

CHAPTER 1

INTRODUCTION

Life expectancy of the United States population has increased from 47 years in 1900 to 76 years in 1996 (AARP, 1996). At the turn of this century nearly 13% of the United States population consisted of people ages 65 years and older (Simmons, Fletcher, Francis 1998). This increase is a dramatic one from that of 1900, when only 4% of the U.S. population was 65 years and older (Simmons et al., 1998). It is projected that in the year 2030 the percentage of elder individuals living in the United States will be at 25% (Simmons et al., 1998).

The proportion of elderly in rural areas is greater than in urban areas (Coburn & Bolda, 1999). These elderly rural residents have lower incomes and are more likely to be classified as poor when compared to their urban counterparts (Coburn and Bolda, 1999). As such, with regard to health care, rural elders must rely more heavily on Medicare and Medicaid than their urban elder counterparts. Further, they are less likely to have supplemental, private insurance coverage (Coburn and Bolda, 1999). These economic factors can have a negative impact on the availability and accessibility of health professionals and services for the rural elderly. That a higher proportion of rural elderly rate their health as fair or poor (U.S. Dept. for Health and Human Services, 1993) is indicative of the fact that the rural elderly truly do face barriers when utilizing their health care providers.

Because the last years of an elder's life are often spent in declining physical functioning, it is imperative that not only do patients access health care but also that patients and providers communicate effectively with one another. Because patient-provider communication is an important mediator that impacts health outcomes (Bierman and Spector, 2001), it is important to identify the communication barriers and improve the lines of communication between patient and provider.

At present there is a lack of research on the types of communication barriers faced by rural elderly when accessing health care. Further, much of the research on the rural elderly is old and outdated (Coburn, 2002). Thus, the purpose of this thesis research is to identify and explore communication barriers faced by the rural elderly when accessing healthcare. Specifically, this thesis research seeks to answer the following research questions: What types of communication barriers do rural elderly face when seeking health care? More specifically, what sorts of patient-provider communication barriers will the rural elderly of South Central Kentucky identify?

Definitions

The following are definitions of some terms used in this study:

1. Elderly – For the purpose of this study, any person over the age of 65.

2. Provider -- Throughout the research the word provider is referred to rather than physician. Although physicians continue to be the main providers of health care, Americans are increasingly receiving much of their primary care from individuals other than physicians. Advanced-practice nurses, nurse practitioners, physicians' assistants, and many other healthcare personnel are involved in specialized care. Consequently, issues of communication that arise in medical settings are by no means the exclusive provinces of the physician.

3. Rural -- Community having less than 20,000 residents.

4. Urban -- Cities with a population of at least 20,000 but less than 50,000.

CHAPTER 2

REVIEW OF LITERATURE

The older population numbered 34 million in 1996, which is about one in every eight Americans (AARP, 1996). The longer a person lives, the more likely that he or she will live even longer. For example, persons who live to be 65 can look forward to living, on average, an additional 18 years (Simmons et al., 1998). The U.S. elderly population is projected to continue to increase, especially beginning in 2011, when the first members of the baby-boom generation reach age 65 (Health and Vital Statistics, 1990). Although chronological age may be a subjective way to project health needs among elders because there is a wide difference in their health status, the age of 65 has been used as a standard since 1935 (Simmons et al., 1998). It was then that Franklin D. Roosevelt established this age as the eligibility criteria for Social Security.

Rural Elderly

The rural elderly have several characteristics that make them unique. Typically the rural elderly have lower incomes and are more likely to be classified as poor than are the urban elderly (Kentucky Cabinet for Health Services, 2002). Consequently, rural elders rely more on Medicare and Medicaid rather than private insurance (Kentucky Cabinet for Health Services, 2002). Rural elderly also commonly rate their health less favorably than do urban elderly (Coburn and Bolda, 1999).

According to data from the 1990 census, the nation's 8.2 million elderly persons living in rural areas comprised approximately 26% of all elderly persons in the United States (Health and Vital Statistics, 1990). Figure 1 shows the percent distribution of the elderly in rural areas by age group.

Figure 1. Percent Distribution of the Elderly in Rural Areas by Age Group

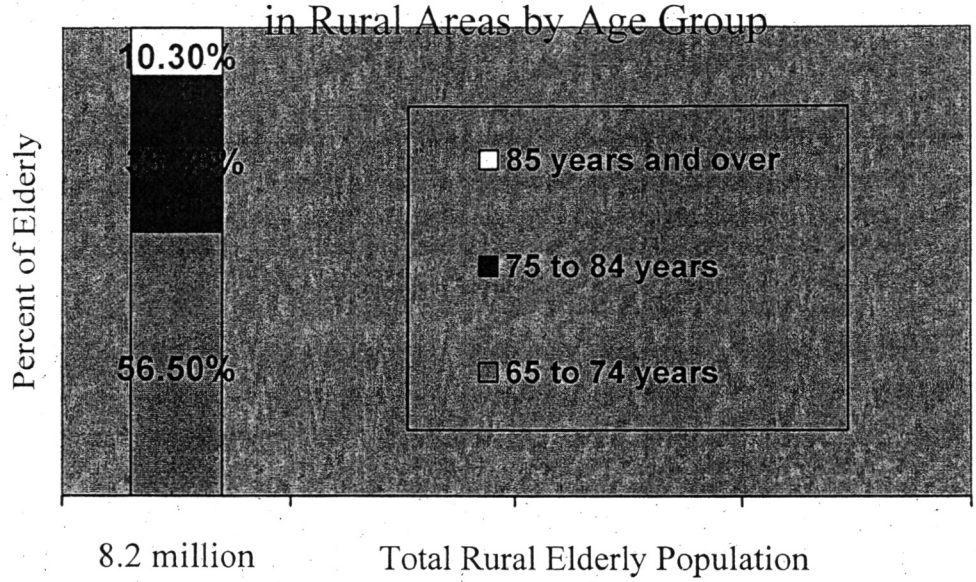
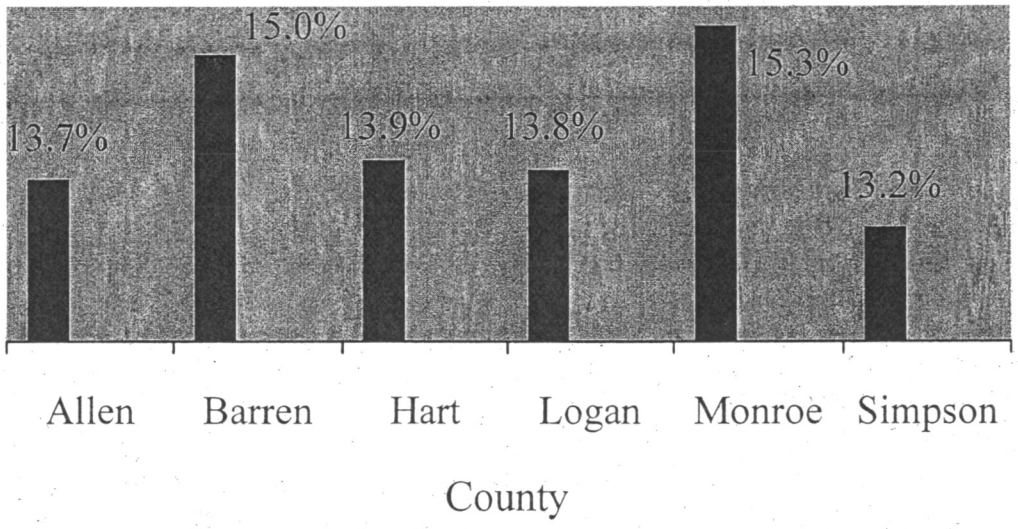


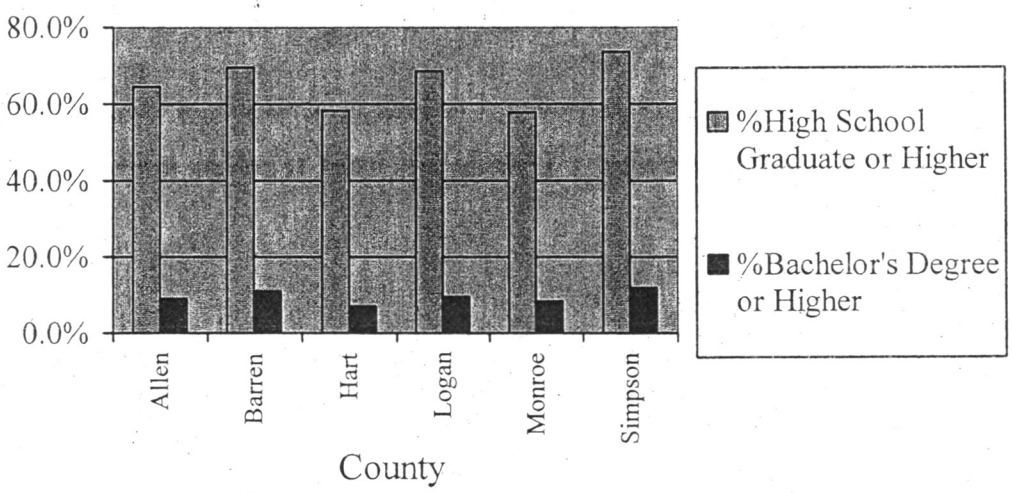
Figure 2 shows the percent distribution of the elderly in rural Barren River Area Development District counties.

Figure 2. Percent Distribution of Elderly in Rural BRADD Counties



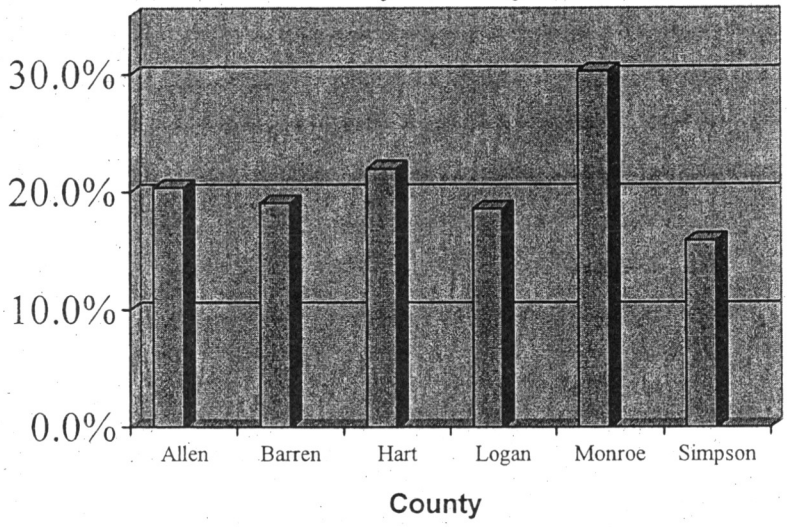
The rural elderly are more impoverished and less educated than the urban elderly. Data from 1991 on educational attainment showed that more than one-third of the rural elderly completed less than nine years of school (Health and Vital Statistics, 1990). According to the 2000 census, 65.35% of the elderly in the Barren River Area Development District completed high school, and 9.52% obtained a Bachelor's degree or higher. Figure 3 shows the breakdown of these statistics by county in the rural Barren Area Development District.

Figure 3. Educational Attainment of Citizens of Rural Counties in BRADD



In 1987, half of the rural elderly were considered poor or had an income within 200% of the poverty level, compared with 37% of the urban elderly. Figure 4 illustrates the percentages of the elderly considered poor according to the rural county in which they live in the Barren River Area Development District.

Figure 4. Percent of the Elderly Considered Poor by County in BRADD



Barriers to Communication

All effective communication involves the creation or exchange of understanding between a sender and a receiver. Personal barriers to communication are always potentially present when people communicate. These barriers arise from the nature of people, especially in their interaction with others. Unless one has had the same experiences as others, it is difficult to completely understand messages from them or to construct messages that others completely understand. For example, a young, urban provider educated at a metropolitan university may have difficulty understanding the concerns of the rural elderly.

Effective collaboration between healthcare providers and patients is dependent upon good communication (Haber, 1999). The satisfaction of older clients is positively associated with the length of their visits with a physician and with the physician's support

of topics initiated by the clients (Greene, 1991). Patients prefer health care providers who are willing to listen, communicate clearly, and show warmth and concern (Sarafino, 1990). In addition, the Agency for Health Care Policy and Research reported that "patients of doctors who encouraged them to discuss health information and ask questions (patient activation) and who chatted with them about personal topics were more apt to report satisfaction with their care" (www.ahcpr.gov). Taking the time to understand the values and beliefs of patients can help the provider overcome communication barriers present due to differences in educational attainment, socioeconomic status, religion, gender, and age (Haber, 1999).

One small study in Albuquerque, New Mexico, brought physicians and patients together to investigate patient-provider discrepancies in medical encounters (Glassheim, 1992). While the elderly said they wanted health providers to listen to them more, the providers said they wanted their older patients to focus and tell them what they were wanting (Glassheim, 1992). In another study only 23% of the time did patients have the opportunity to finish his or her explanation of concerns before interruption (Beckman and Frankel, 1984). The provider interrupted, on average, after the patient had spoken for only 18 seconds (Beckman and Frankel, 1984).

Use of Jargon

The use of jargon and technical language is another important factor in poor communication. Patients understand relatively few of the complex terms that providers often use. The largest study of health literacy, performed in 2001, found that of English

speaking patients at two public hospitals, one third were unable to read basic health information. Also, 42% couldn't understand directions for taking medications on an empty stomach, and 26% didn't understand a standard appointment slip (Parker & Schwartzberg, 2001). Seniors are more likely to have trouble reading, understanding, and using the health information they receive (www.HealthNews.org).

In some cases, explanations filled with jargon may be used to keep the patient from asking too many questions or from discovering that the provider is not certain what the patient's problem is (Waitzkin, 1985). More commonly, however, a provider's use of jargon is simply a carry over from their technical training (Waitzkin, 1985). Because providers learn a complex vocabulary that is useful for them when communicating with other healthcare professionals, they merely forget that the average citizen does not understand such terms (Waitzkin, 1985). Other reasons why physicians persist in using perplexing language are as follows: the belief that accurate comprehension of a medical problem might increase the client's stress level; the fact that difficult-to-understand terms may be conversation stoppers, making more time available for seeing other clients; the belief that the use of big words elevates the status and authority of the practitioner; and the belief that lack of comprehension may make errors more difficult to detect and litigation less likely (Sarafino, 1990). The extreme opposite of this scenario involves the provider using overly simplistic explanations. Such behavior can make the patient feel helpless or childlike and thus forestall additional questioning (Waitzkin, 1985).

Providers Perception of Patients' Understanding

Typically, providers underestimate the patient's ability to understand information about the origins, diagnosis, prognosis, and treatment of their disorders (McKinley, 1975). A study of a group of low class patients' comprehension of 13 terms used by their physicians found that each term was understood by one-third of the patients (McKinlay, 1975). However, the physicians expected these clients to have even less comprehension than was reported (McKinlay, 1975). Nonetheless, patients can be motivated to learn about their condition, and do a reasonable job of it, despite the frequent absence of adequate explanations from the provider (Waitzkin, 1985).

Companions at Medical Visits

Older men are less likely than women to bring a companion when visiting a doctor. However, when they do have a companion they are more likely to bring that person into the examining room to help them communicate with the doctor (Beisecker, 1990). Older women, conversely, tend to bring companions primarily for transportation or companionship, but visit with the doctor alone (Beisecker, 1990). Although there are benefits to having a companion in the room during an examination, an elderly person may feel invisible at a medical visit if the health care professional speaks exclusively to the companion or speaks as if the patient is an object rather than a person (Kaufman, 1970). A patient may be spoken to as an object intentionally to try to keep the patient quiet during an examination, test, or procedure (Zimbardo, 1969). On the other hand, this treatment may

be employed unintentionally because the patient has taken the form of an object as "it" is the focus of the provider's attention (Zimbardo, 1969).

Provider's Assignment of Negative Stereotypes to Patients

Communication may also be damaged when providers encounter patients or diseases that they would prefer not to treat (Morgan, 1985). Assigning negative stereotypes to patients may contribute to problems in communication and succeeding treatment. Research shows that physicians give less information, are less supportive, and demonstrate less clinical performance with patients of lower socioeconomic class than is true for more advantaged patients (Bartlett, et al., 1984).

Sexism is a problem in medical practice as well. Male physicians and female patients do not always communicate well with each other. The matching of gender between patient and practitioner appears to foster more rapport and discovery, which may enhance communication (Levinson, McCollum, and Kutner, 1984).

Patients who are categorized as seeking treatment for psychological disorders such as depression or anxiety also induce negative reactions from physicians. This situation is certainly a concern for the elderly population as over 200,000 elderly people suffer from serious psychological disorders such as depression, anxiety syndromes, and dementia. Hundreds of thousands more suffer from milder forms of psychological problems and are reluctant to seek help from their providers because of the aforementioned stereotypes (www.scp.nl).

In general, physicians like their healthier patients more than their sicker ones, and they prefer acutely ill to chronically ill patients (Hall, et al., 1994). Patients with chronic illnesses pose uncertainties and questions about prognosis that those with acute diseases do not (Butler, 1978). Because the last years of an elder's life are often spent in declining physical functioning, they are more susceptible to chronic illnesses. These illnesses, such as heart disease, cancer, and arthritis, are taking a greater toll on the elderly as well as their providers (KY Cabinet for Health Services, 2002).

Finally, many physicians share negative perceptions of the elderly along with the rest of society (Ford and Sbordone, 1980). Ageism is common among all types of people, including healthcare professionals. Many health professionals expect older people to be frail, confused, depressed, overly talkative, needy, or quarrelsome (AARP, 1996). There is evidence that the elderly are less likely to be resuscitated in emergency rooms or given active treatment protocols for life-threatening diseases (Roth, 1977). These problems may be worsened by any communication difficulties the elderly person has (Haug and Ory, 1987). The negative attitudes of physicians seem to be reciprocated in the elderly, in that among those 65 and older only 54% expressed high confidence in physicians (Hall et al., 1994).

Additional Barriers to Communication

Some additional factors to consider are that many doctors say that they feel uncomfortable with "counseling" patients, feeling that patients often ignore their advice on matters such as smoking and losing weight. Also, communication takes time; doctors say

their schedules are full. Finally, insurance companies rarely pay for as much time with the doctor as patients may want or need. Without specific training in working with the elderly, healthcare professionals may simply be unaware of their needs (AARP, 1996).

Reducing Barriers to Communication

Personal barriers to effective communication can be reduced by conscious efforts of the provider and patient to understand each other's frame of reference and beliefs. Empathy with those to whom messages are directed may be the surest way to increase the likelihood that the messages will be received and understood as intended. The following questions are designed to increase interpersonal communication and effectiveness:

- Do you make eye-to-eye contact (Haber, 1999)?
- Do you have a caring but not condescending tone of voice (Haber, 1999)?
- Are you and your clients comfortable with touching? If so, will this enhance your rapport and communication (Haber, 1999)?
- Do you engage in reciprocity of information, and if necessary, are you willing to self-disclose (Haber, 1999)?
- Do you let your clients talk enough, provide someone who will, or refer to a support group that will listen (Haber, 1999)?
- Is it possible to gain insight into your client's lifestyle by making a home visit or getting feedback from someone who has (Haber, 1999)?

Patients' Contribution to Faulty Communication

The provider is not to blame for all of the communication barriers between him/her and his/her patient. Patients also contribute to faulty communication. One of the major problems is patient anxiety (Bush and Osterweis, 1978). During a visit to a provider, anxiety is often quite high. Anxiety can make it difficult to concentrate, and process and retain information, thereby impairing the learning process.

Another factor that influences the patient's ability to understand and retain information about his/her condition includes education about the disorder and experience with the disorder. Patients for whom an illness is new and who have little prior information about a disorder show the greatest distortion in their explanations of their health problems (DiMatteo and DiNicola, 1982).

In addition, patients respond to different cues about their illness than do providers. While the patient places emphasis on pain and symptoms that interfere with his/her daily activities, providers are more concerned with the severity and treatment processes of a condition. This difference in focus can lead to faulty communication because the patient may misunderstand the provider's emphasis on factors that he/she considers incidental, thereby paying little attention when vital information is being relayed (Korsch and Negrete, 1972).

Patients may give providers faulty cues about their true concerns. As many as two-thirds of patients make medical appointments because they fear they have a truly serious disease such as cancer or heart disease (Reader, Pratt, and Mudd, 1957). Particularly among the elderly, there may still be the belief that when symptoms signify a serious

disorder, physicians do not tell the patient (Reader, Pratt, and Mudd, 1957). In addition, patients may fear asking questions because they do not think they will receive straightforward answers. In addition, providers may automatically assume that because no questions have been asked, the patient does not want any information (Reader, Pratt, and Mudd, 1957).

An additional characteristic of elderly patients that contributes to communication barriers is that elderly patients are less likely to seek health information (AARP, 1996). Elderly patients are less likely than younger ones to ask questions of their doctors and nurses and are more likely to comply with "doctor's orders" rather than take part in the decision making process (AARP, 1996). The good communication skills of a person considered to be trustworthy, expert, and powerful should not be underestimated (Haber, 1999). Elderly patients prefer to avoid details and instead rely on the doctor's expertise. Patients 65 and older may view asking questions as bothering or insulting the doctor (AARP, 1996). They may not realize that they can get reliable information from other health professionals (AARP, 1996). In addition, the many changes that have occurred during an elderly person's lifetime in how medical care is delivered may add to the problem of communication (AARP, 1996). Davis and Megilvy (2000) suggest that rural older adults found the formal health care system too complex and confusing, particularly as the complexity of health problems increased.

Overall, communication barriers exist between all patients and providers. However, the elderly are of great concern due to the various additional complications they face as they age and attempt to access the health care system. It is neither the sole

responsibility of the provider nor of the patient to remedy these issues. Instead, research must be performed in order to more specifically identify the communication barriers pertinent to each elderly group and identify the solutions to these barriers.

CHAPTER 3

METHODOLOGY

Research Question

What sorts of communication barriers will the rural elderly of South Central Kentucky identify?

Population

The research population consisted of the elderly residing in rural counties in the Barren River Area of District Development (BRADD) of South Central Kentucky. The Barren River Area Development District includes the following counties: Allen, Barren, Butler, Edmonson, Hart, Logan, Metcalfe, Monroe, and Simpson, and Warren. Butler and Edmonson counties were not included in the study because these two counties were part of a larger, ongoing study and the researcher did not want to introduce design contamination to that study. Because the director of the senior center could never be reached, Metcalfe County was also not included in the study. Warren County was not included in the study because it is not considered rural. One participant did not reside in the BRADD area (Trigg County) but he participated in the senior center in Monroe County. Within the counties of Allen, Barren, Hart, Logan, Monroe, and Simpson, 14.15% of the population was 65 or older in 2000 (Kentucky State Data Center, 2001). Figure 5 shows the distribution of participants that were recruited from each county.

Figure 5. Distribution of Participants Recruited from each County

County	Number of Participants
Allen	7
Barren	13
Hart	7
Logan	9
Monroe	19
Simpson	4

Eligibility Criteria

Those who participated in the study were 65 years of age or older and capable of accessing the local senior centers where the interviews took place.

Participant Recruitment

Following approval by the Human Subjects and Review Board at Western Kentucky University, the regional director of the BRADD Senior Centers was contacted and permission was obtained to recruit the seniors in these facilities for participation into this study. Times and dates were arranged with the directors of the individual centers, and six counties were visited. The director of the senior center introduced the researcher to the senior center participants and gave a general explanation about the purpose of the study. The participants volunteering to complete

the survey were taken to a private area and informed consent form was obtained. The informed consent form was explained to those unable to read due to literacy and vision impairments issues. After signing the informed consent document, the questionnaire was read to each participant; answers were recorded verbatim. At times, questions were reworded if the participant did not understand the original wording of the question. To ensure anonymity, each participant was assigned a unique identifying number. A convenience sample of sixty subjects was interviewed. One participant did not meet the age requirements and was excluded from the study (n=59).

Data Collection

The following was explained to the subjects: they were not obligated to participate in the study, they could stop the interview at any time, and they could skip any questions they did not wish to answer. The interview guide was administered in the form of a face-to-face dialogue. Each interview lasted for an average of twenty minutes.

Measures

Demographic Information

Standard demographic information was obtained about each of the participants. Age was measured as a continuous variable. For purposes of descriptive statistics, age was trichotomized as such: 65-74, 75-84, 85 and older. Ethnicity, gender, and county of residence were assessed categorically. Level of educational attainment was

categorized as such: 8th grade or less, 9th – 11th grade, high school graduate/GED, some college, college graduate, graduate school. For purposes of analysis, level of education was recoded two ways: 1. less than high school, high school, more than high school; and 2. less than high school graduate, high school graduate or more. Income was measured continuously, but recoded into the following categories for purposes of analysis: less than or equal to $4999/year, $5,000-9,999/year, $10,000-19,999/year, $20,000 or more/year. The income categories were simply chosen as such because the distribution of the participants fell into these ranges.

Insurance was measured categorically as HMO, Private, Medicare, Medicaid, none, Private and Medicare, or Medicare and Medicaid. However, it was simply recoded as Government Program or Private and Government Programs. Who the participant lives with was measured categorically as alone, with spouse, with family member (other than spouse), or with an unrelated individual. For purposes of analysis who the participant lives with was recoded three ways. The first of those ways was alone versus with others. The second was with spouse versus alone versus with others. The third was with spouse versus all others.

Health Information

Health information was obtained as well. The reason a participant last saw a health care provider was measured categorically as routine check-up, screening, emergency, prescription, or other. For purposes of analysis the data were recoded into two categories: prevention and treatment. Prevention included routine check-up,

screening, and some of those listed under the category "other". Treatment included emergency, prescription, and the remainder of those listed under the category "other." Often times a participant responded "other" because the issue did not clearly fall into one of the previously assigned categories, However, upon collection of the data it was clear whether a response was prevention or treatment related. The responses deemed "other" by the participant were recorded verbatim and later analyzed by content in order to assign the data into either the category prevention or treatment.

The last time a participant saw a health care provider was measured categorically as well as where the participant mostly obtains health care. The original categories under the last time a participant saw a health care provider were as follows: within the last week, month, three months, six months, nine month, year, and over a year ago. The original categories under where the participant mostly obtains health care were primary care physician, hospital, clinic, and other. Again, for purposes of analysis both of these data were recoded. The last time a participant saw a health care provider was recoded into the following categories: within the last month, within the last six months, within the last year, and over a year ago. Where the participant mostly obtains healthcare was recoded as primary care physician versus all others. In addition, the participant was asked to respond to whether or not the practicing county of his/her regular family physician was the same as the county in which he/she resided. If they responded that their regular family physician did not practice in the county in which they resided, the practicing county of their regular family physician was measured categorically. Those categories were Warren County, Barren County, Hart County, and

Monroe County. The last question in this section, the gender of the participant's regular family physician, was measured categorically.

Scaled Response Questions

Next, items related to barriers to communication with the participant's health care providers were measured via a five point semantic differential. The participant was instructed to answer the questions according to the scale which ranged from one to five. A one indicated that they strongly disagree with the statement being read to them and a five indicated that they strongly agree with the statement being read to them.

Open-ended Questions

The following open-ended questions asked were as follows: "What are the biggest communication barriers you have with your health care providers?"; "What sorts of things make a good healthcare provider?"; and "Have you ever refused to see a healthcare provider again? If so, why?" Finally, the responses to the open-ended questions were recorded verbatim and coded as such. Then, two groups of four raters participated in inter-rater reliability exercises to collapse the second and third open-ended question responses into categories. Each question depended on an inter-rater reliability result of .75.

Responses from the first categorized open-ended question, "What sorts of things make a good health care provider?" were assigned to the following categories: skills, personality, structural, or other. Many respondents listed more than one item as

regards to what makes a good health care provider. In each of these cases only the first response was analyzed. Items listed under the skills category related to topics of communication issues such as listening, speaking, and attentiveness and also to topics of ability such as experience, knowledge, and meeting medical needs. Items listed under the personality category included concern for the patient, caring, sympathetic, interested in the patient, personable, friendly, and trustworthy. Items listed under the structural category included responses regarding convenience, efficiency, availability, and time spent with the patients. Finally, items listed under the 'other' category were those in which people responded that they didn't know the answer to that question or had responses such, "I don't hardly go to the doctor unless I need to."

Responses from the second categorized open-ended question, "Why have you ever refused to see a health care provider again?" were categorized as follows: provider competency issue, interpersonal communication issue, and other. An example of a response that fell into the category of a provider competency issue is "I just didn't think he was a good doctor. He was a likeable person, but I think he needed more education." An example of a response that fell into the category of an interpersonal communication issue is "I just didn't care for his attitude. He would ask me things like 'What's wrong with you?...Well, how do *you* know *that's* what it is?" Answers such as "I've been lucky all my life and haven't needed too many doctors" fell into the 'other' category.

Data Analysis

To provide an overall description of the data, frequency distributions were computed for categorical data and measures of central tendency were computed for continuous variables.

CHAPTER 4

RESULTS

Demographic Characteristics

A total of 59 participants answered the interview guide questions. Ages of the participants ranged from 65 to 92 (median = 77). The majority of the participants were Caucasian (89.8%) and female (72.9%). Most of the participants had completed eight grade (27.1%), with high school graduates in the next highest category (12%). Almost one third of the participants earned less than $10,000 per year (30.5%). Most of the participants lived alone (76.3%). Table 1 displays the characteristics of the sample of the rural elderly by describing the distributions of the demographic characteristics of the respondents.

Health Related Information

Most of the participants (62.7%) relied only on a government program for their health insurance. A primary care physician was where 83.1% of the participants obtained their healthcare. Over three fourths of the participants (78.9%) reported that their regular family physician practiced in the county in which they reside. Males comprised 78.2% of the regular family physicians of the participants. At the time of the interview, 52.5% of the participants had visited a health care provider in the past month. All but 3.4% had visited a provider within the last nine months.

Table 2 displays the characteristics of the sample of the rural elderly by describing the distributions of the health-related information of the respondents.

Barriers to Communication

Table 3 presents data on the barriers to communication faced by the rural elderly. A mean split was performed on the scaled response questions in order to minimize potential bias introduced by the social desirability of participants who may have consistently responded high as a result of over rating their health care providers. More than half of the participants disagreed with the following statements which are related to the qualities of the provider: my health care provider spends enough time with me at medical visits (55.9%, x=4.24, SD=.92), and my health care provider speaks to me as if I am a person and not an object (52.5%, x=4.44, SD=.57). More than half of the participants agreed with the following statements which are, again, related to the qualities of the provider: my health care provider uses medical terminology or technical words that I do not understand (61.0%, x=1.92, SD=.99), I feel that my health care provider doesn't want to treat me (50.8%, x=1.53, SD=.54), my health care provider rushes me through medical visits (59.3%, x=1.80, SD=.83), and my health care provider would not tell me if my symptoms meant I had a serious disorder (60.3%, x=1.95, SD=1.00). In contrast, 55.9% of the participants disagreed that it is difficult for them to understand their health care provider due to his/her accent (x=1.53, SD=.68), and 89.8% disagreed that their health care provider uses overly simple explanations when

speaking with them (x=2.22, SD=4.02). Another 55.9% disagreed that their health care provider interrupts them during office visits (x=1.49, SD=.63).

The remaining statements were more oriented to the qualities of the participants. More than half of the participants disagreed that they have the opportunity to finish explaining all of their concerns during office visits (62.7%, x=4.19, SD=.82), if they are informed they have a certain condition, they try to learn about its treatment and symptoms (57.6%, x=4.24, SD=.86), they communicate well with their health care provider (59.3%, x=4.34, SD=.60), and they can get reliable health information from health care providers other than their physician (50.8% x=3.03, SD=1.39). More than half of the participants agreed that they do not ask questions at medical visits because they do not want to bother the health care provider (54.2%, x=1.64, SD=.74) and that they prefer to just comply with doctor's orders regarding their health rather than take part in the decision making process (69.5%, x=3.59, SD=1.22). In contrast, more than half of the participants disagreed that they feel anxious or nervous at medical visits (59.3%, x=2.51, SD=1.25), they do not ask questions at medical visits because they do not want to insult the health care provider (52.5%, x=1.59, SD=.67), the medical and technological changes that have occurred in their lifetime have left them confused (74.5%, x=2.20, SD=.98), and it is difficult for them to hear their health care provider (57.6%, x=1.90, SD=1.06). In addition, 61.0% reported they seek health care because they fear they may have a serious disorder (x=1.97, SD=1.08).

Finally, the results were split on the following two statements: "I do not ask questions at medical visits because I do not think I will get a straightforward answer" (x=1.60, SD=.75) and "When someone goes with me to a medical visit, the health care provider speaks just to him/her, leaving me out of the conversation" (x=1.52, SD=.55).

Open-ended Questions

When asked what makes a good health care provider, 48.3% of the participants cited the skills of the provider, 31.0% cited the personality of the provider, and 15.5% cited the structure of the provider.

Twenty-three respondents answered that they had refused to return to a health care provider at one time or another. Of those respondents, 34.8% of their answers were attributed to provider competency, while 52.1% were attributed to issues of interpersonal communication.

When asked "What are the biggest communication barriers you have with your health care provider?," 38 participants (n=59) responded that they don't have any problems at all. Of the remaining 21 participants, only seven actually responded directly to the question citing a communication barrier. Some reasons listed by those respondents included: "Sometimes when I ask questions the doctor beats around the bush rather than answers me." The participants also gave reasons such as "Not being able to hear him" and "I've had a doctor who seemed like he wasn't interested in what was wrong with me." In addition, seven more participants answered the question and

implied that the provider not spending enough time with them was their biggest communication barrier.

CHAPTER 5

DISCUSSION

What Types of Communication Barriers do Rural Elderly Face when Seeking Health Care?

One of the communication barriers that the literature stated the elderly faces involved the health care provider using medical terminology or technical words that the patients do not understand (Samora, Saunder, and Larson, 1961). Over half of the participants in this study also felt that their provider used medical terms they did not understand (61.0%). It has already been found that elderly people have more trouble than most. Couple this with the lower educational attainment of this particular study group and it is obvious that the health literacy rate of this study group is lacking. Evidence of the significance of this barrier is in a response given by one participant. When asked to list characteristics of a good health care provider, the participant said, "...good communicator, explains things so that I can understand." Another stated, "They make you understand what you need to do. . . ."

Another barrier that the literature cited is faced by the elderly that was faced by this study group was the feeling that their health care provider doesn't want to treat them (50.8%). This sentiment could be attributed to a variety of factors. Since the study group relies heavily on Medicare and Medicaid, the result is less profit for the provider and thus could be one factor. In addition, the rural elderly are more likely to have chronic illnesses

rather than acute; thus stereotyping may be taking place in the form of ageism. Because many of the participants cited caring and compassion as characteristics of a good health care provider, it seems obvious how this factor is a significant barrier as well.

In conjunction with the literature, feeling that their health care provider would not tell them if their symptoms meant they had a serious disorder was a problem for these participants also (60.3%). It is difficult to speculate about whether this feeling is fueled by perhaps pre-existing communication barriers or if it is a barrier in and of itself. Nonetheless, this particular problem could be due to low health literacy as well. One participant said, "The number of tests they run on me is confusing. It makes it difficult for me to know what ails me."

Over half of the participants concurred with previous findings that they do not have the opportunity to finish explaining all of their concerns during office visits (62.7%) and they feel rushed through medical visits (59.3%). The high percentage of Medicare and Medicaid participants could certainly contribute to this factor. Physicians do indeed spend less one on one time with the patients who participate in these programs versus those who have private insurance. Numerous responses from patients related to these two interview questions. One participant said, "She doesn't stay in the room long enough. If she stayed you could explain your problems more accurately." Another said, "She doesn't seem to want to spend too much time with me and sometimes I wonder if she knows what all she's giving me. I only have a blood pressure problem but I take 17 pills a day." This example is indeed a strong one of how communication barriers are important issues concerning the health and welfare of the patient.

Over half of the participants agreed that if they are informed they have a certain condition they do not try to learn about its treatment and symptoms (57.6%), which the literature stated is true for patients. Not learning about a condition makes it more difficult for the patients to discuss their health with the provider and makes it more difficult for the provider to render service to the patient. One participant said, "Perhaps I don't know what to ask the physicians, and that's the reason why I don't ask questions at visits." Another participant had a bit of a different perspective and said, "I don't ask questions at visits because he's supposed to tell me. I tell him what's wrong with me and that's it." This communication barrier might be remedied by empowering the patient via patient education. Not only should patients be educated about their particular condition, but especially be educated as to how they can access more information concerning their illness.

More than half of the participants agreed that they do not ask questions at medical visits because they do not want to bother the health care provider (54.2%). However, those participants did not also say that they aren't asking questions for fear of insulting the provider or not getting a straightforward answer. Seemingly, this barrier is related to time and communication. If the patients are feeling rushed or pressured to remember the issues they wanted to discuss with the provider, they may forget important questions and feel that taking more of the providers time to remember to ask them is bothersome. For example, one participant said, "They want to get through with me and go to the next patient. I don't ask questions because either I don't think of them or they don't give me time." Another response was, "He's always in a hurry and maybe I can't remember to ask something. I remember these things after I've left."

Not feeling confident as a patient is another factor that may contribute to the communication barriers. The participants stated that they prefer to just comply with doctor's orders regarding their health (69.5%). They also stated that they seek health care because they fear they may have a serious disorder (61.0%). These responses indicate that the patients may be giving providers faulty cues about their true concerns and furthermore aren't confident enough to interject and share their true ailment with the provider. One participant said, "Sometimes when I ask questions the doctor beats around the bush rather than answers me. When I got my blood tests and asked about it he just said it was fine. He's always done that, he just tells me what he wants me to know." Upon asking the participant if he would ever confront his provider about this communication issue he referred to his previous answer and said, "No, I just do what the doctor tells me."

Limitations

The method of data collection was a face-to-face interview by a single interviewer. One limitation of this method is that the presence of the interviewer may affect a respondent's perception and answer. This introduces instrumentation bias. However, because of the potential for low literacy rates and vision impairments, this method of data collection was deemed most appropriate. In addition, the data are potentially limited by intra-rater reliability, which could bias results. This limitation is due to the subjective nature of that task. In addition, the instrument was not pilot tested.

The sample size was small. Furthermore, participants in this study were all elderly citizens who attended a senior center in the Barren River Area Development District of South Central Kentucky. Unlike quantitative research, qualitative research does not aim to produce findings that are necessarily representative of a larger population. Findings from qualitative research can be generalized in certain circumstances (Morse, 1999). Therefore, these participants may be neither representative of all rural elderly citizens in the United States nor Kentucky. In addition since this group was a convenience sample the results may not be representative of how most rural elderly citizens feel, thus lacking in value of generalization.

Response effects introduce another potential source of error. The data were all self-reported and are thus subject to biases of recall and social desirability. Most of the participants did not appear sure of themselves when answering the scaled response questions. In fact, most of them preferred to answer the scaled response questions with a "yes" or a "no" rather than a number. Nonetheless, the subjects were encouraged to choose a number and if they never did so a '1' was chosen to indicate disagreement with the statement read and a '5' to indicate agreement with the statement read to them. This method of recording the data was further incentive to utilize a mean split. This complication also is an indication of the lack of reliability of the results.

Future Studies

Findings from this thesis research suggest that there are indeed communication barriers faced by the rural elderly when accessing healthcare. Whether these barriers are specific to residents of South Central Kentucky is not known. Given that the literature cites these barriers as ones shared by all elderly it is necessary to determine what other, if any, specific barriers are faced by the rural elderly. In a future study the sample size should indeed be larger, and elderly from rural areas across the nation should be interviewed. In addition, focus groups might be more effective in getting responses to the open ended questions. If the participants hear the response of their friends, they may be more likely to think of a response rather than answering that they don't have any problems or they don't know the answer to the question being asked. If focus groups were not used then the semantic differential scale needs to be reevaluated. Perhaps a sort of color scheme or facial expression system could be used. In addition, in a future study it would be interesting to compare the results a rural elderly sample population with that of an urban elderly sample population and determine if differences exist between these two groups.

Conclusions

This study was designed to investigate the communication barriers that exist between the rural elderly and their health care providers. This study satisfies the purpose of expanding and updating what is known about the communication barriers faced by rural when accessing health care. This study also demonstrates that further research on

communication barriers between the rural elderly and their health care providers is warranted in order to empower this group of people.

Good communication requires both the ability to listen and to impart relevant information. Effective and better ways of communicating with elderly patients needs to be investigated. Specific barriers to effective communication such as health literacy, assigning negative stereotypes, and time spent with the patient should be addressed. Strategies to help patients ask questions about their illnesses, tests, and medications should be developed.

Although communication issues will be eminent between any collective groups of people, it is important to realize the intensity of the barriers that exist among the rural elderly and the significance of lessening those barriers. They are an especially vulnerable group of people considering their lower income and education levels. It is not too late to correct the former mistakes of the health care system that perhaps overlooked this group of people. Now is the time to empower the elderly and facilitate their access to health care. A deep history lies in these people, and the future is uncertain without their wisdom.

REFERENCES

American Association of Retired Persons: A profile of older Americans: 1995, Washington, D.C., 1996, the Association.

Bartlett, E.E., Grayson, M., Barker, R., Levine, D.M., Golden, A., & Libber, S. (1984). The effects of physician communication skills on patient satisfaction, recall, and adherence. *Journal of Chronic Diseases, 37,* 755-764.

Beckman, H.B., & Frankel, R.M. (1984). The Effect of Physician Behavior on the Collection of Data." *Annals of Internal Medicine, 101,* 692-696.

Beisecker, A. (1990, November). *The older patient's companion.* Paper presented at the 43rd Annual Scientific Meeting of the Gerontological Society of America, Boston.

Bierman, A., Spector, W., AHRQ Task Force on Aging. *Improving the Health and Health Care of Older Americans.* A Report of the AHRQ Task Force on Aging. Rockville (MD): Agency for Healthcare Research and Quality; 2001. AHRQ Pub. No. 01-0030.

Bush, P.J., & Osterweis, M. (1978). Pathways to medicine use. *Journal of Health and Social Behavior, 19,* 179-189.

Butler, R.N. (1978). The doctor and the aged patient. In W. Reichel (ed.), *The geriatric patient* (pp.199-206). New York: HP.

Coburn, A.F. (2002) Journal of Rural Health. "Rural Long-term Care: What Do We Need to Know to Improve Policy and Programs?" Vol. 18, No. S. (pp. 256-269).

Coburn, A.F., and Bolda, E.J. (1999) Rural elderly and long-term care. In Ricketts, T. (Ed.) "Rural Health in the United States" (pp. 179-189). New York: Oxford University Press.

Davis, R., & Magilvy, J. (2000). Quiet pride: The experience of chronic illness by older adults. *Journal of Nursing Scholarship,* 32(4), 385-390.

DiMatteo, M.R., & DiNicola, D.D. (1982). *Achieving patient compliance: The psychology of the medical practitioner's role.* New York: Pergamon.

Ford, C.V., & Sbordone, R.J. (1980). Attitudes of psychiatrists toward elderly patients. *American Journal of Psychiatry, 137,* 571-575.

Glassheim, C. (1992). *Health Partners Program mimeograph.* Albuquerque, New Mexico: The University of New Mexico School of Medicine's Primary Care Curriculum.

Greene, M. (1991, July). *Determinants and outcomes of the physicians-elderly patient initial medical encounter* (Final report for the AARP Andrus Foundation). Washington, DC.

Haber, D. (1999). *Health Promotion and Aging: Implications for the Health Professions*. New York: Springer Publishing Company.

Hall, J.A., Irish, J.T., Roter, D.L., Ehrlich, C.M., & Miller, L.H. (1994). Gender in medical encounters: An analysis of physician and patient communication in a primary care setting. *Health Psychology, 13,* 384-392.

Haug, M.R., & Ory, M.G. (1987). Issues in elderly patient-provider interactions. *Research on Aging, 9,* 3-44.

Herrick, Devon K. (2002). Is Medicare too Stingy? *National Center for Policy Analysis, Brief Analysis No 421.*

Health and Vital Statistics. (1990). U.S. Department of Health and Human Services. Center for Disease Control and Prevention. National Center for Health Statistics. www.cdc.gov/nchs/nhis.htm

http://www.abcpr.gov/rearch/nov98/raz.htm June 1,2003

http://12.42.224.153/HealthNews/HealthNewsFeature/hnf082502.htm June 1, 2003

http://www.scp.nl/boeken/cahiers/cah155/uk/persbericht.htm June 1, 2003

Kaufman, M.R. (1970). Practicing ggod manners and compassion. *Medical Insight, 2,* 56-61.

Kentucky Cabinet for Health Services. Office of Aging Services Newsletter. Sept. 2002.

Korsch, B. M., & Negrete, V.F. (1972). Doctor-patient communication. *Scientific Aamerican, 227,* 66-74.

Levinson, R.M., McCollum, K.T., & Kutner, N.G. (1984). Gender homophily in preferences for physicians. *Sex Roles, 10,* 315-325.

McKinlay, J.B. (1975). Who is really ignorant – physician or patient? *Journal of Health and Social Behavior, 16,* 3-11.

Morgan, D. L. (1985). Nurses' perceptions of mental confusion in the elderly: Influence of resident and setting characteristics. *Journal of Health and Social Behavior, 26,* 102-112.

Morse, J. M. (1999). Qualitative generalizability. *Qualitative Health Research,* 9, 5-6.

Parker, Ruth M. & Schwartzberg, Joanne G. (2001) Widespread Ignorance Has Triggered Silent Epidemic. *Postgraduate Medicine,* 109, 5.

Reader, G.C., Pratt, L., & Mudd, M.C. (1957). What patients expect from their doctors. *Modern Hospital, 89,* 88-94.

Roth, J. (1977). Some contingencies of the moral evaluation and control of clientele: The case of the hospital emergency service. *American Journal of Sociology, 1972*, 836-839.

Samora, J., Saunders, L., & Larson, R.F. (1961). Medical vocabulary knowledge among hospital patients. *Journal of Health and Social Behavior, 2,* 83-89.

Sarafino, E. (1990). *Health psychology: Biopsychosocial interactions*. New York: John Wiley & Sons.

Simmons L, Fletcher K, Francis D: The geriatric resource model of care: a vision for the future. In Abraham I, Fulmer T, Milisen K, editors: Advances in geriatric nursing, *Nurs Clin North Am* 33(3):481, 1998.

U.S. Census Bureau, Census 2000. Summary Population and Housing Characteristics: Kentucky. www.census.gov/prod/cen2000/phc-1-19.pdf (May 13, 2003)

Waitzkiin, H. (1985). Information giving in medical care. *Jounal of Health and Social Behavior, 26,* 81-101.

Zimbardo, P.G. (1969). The human choice: Individuation, reason, and order versus deindividuation, impulse, and chaos. In W.J. Arnold & D. Levine (Eds.), *Nebraska symposium on motivation.* Lincoln: University of Nebraska Press.

INFORMED CONSENT DOCUMENT

Project Title: Barriers to Communication in Healthcare: Perceptions of the Rural Elderly

Investigator: Nicole Arachikavitz Department of Public Health (270) 393-9660

Faculty Sponsor: Dr. Marilyn M. Gardner, Department of Public Health (270) 745-5864

You are being asked to participate in a project conducted through Western Kentucky University. The University requires that you give your signed agreement to participate in this project.

I will explain to you in detail the purpose of the project, the procedures to be used, and the potential benefits and possible risks of participation. You may ask me any questions you have to help you understand the project. A basic explanation of the project will be read to you. Please listen to this explanation and discuss with me any questions you may have.

If you then decide to participate in the project, please sign on the last page of this form at this time. You will be given a copy of this form to keep.

1. **Nature and Purpose of the Project:** The purpose of this project is to explore barriers to healthcare for the rural elderly. Specifically, I wish to investigate the barriers of communication.

2. Explanation of Procedures: First you will be asked a list of questions about yourself. Then, you will be asked a list of questions about your beliefs concerning healthcare. You may choose to answer any or none of the questions I ask you.

3. Discomfort and Risks: It will take about 15 minutes to answer these questions. Other than the time it takes, there are no risks to participating in this research

4. Benefits: The answers that you give me will be added to the responses given by other people. The information that we learn will be used, ultimately, to address the problems faced by the rural elderly with regards to their health care.

5. **Confidentiality:** I will not ask you for your name on the survey, so your responses will be completely anonymous. Also, no one else, other than my professors, will have access to any of

the information you give me. All of the completed surveys will be kept in a locked filing cabinet.

6. **Refusal/Withdrawal:** You may refuse to answer any question within the survey or refuse to participate all together. Refusal to participate in this study will have no effect on any future services you may be entitled to from the University or the senior center. Anyone who agrees to participate in this study is free to withdraw from the study at any time with no penalty.

You understand also that it is not possible to identify all potential risks in an experimental procedure, and you believe that reasonable safeguards have been taken to minimize both the known and potential but unknown risks.

_____ _____

Signature of Participant Date

_____ _____

Witness Date

THE DATED APPROVAL ON THIS CONSENT FORM INDICATES THAT
THIS PROJECT HAS BEEN REVIEWED AND APPROVED BY
THE WESTERN KENTUCKY UNIVERSITY HUMAN SUBJECTS REVIEW BOARD
Dr. Phillip E. Myers, Human Protections Administrator
TELEPHONE: (270) 745-4652

BARRIERS IN HEALTHCARE COMMUNICATION: PERSPECTIVES OF THE RURAL ELDERLY

First I will be asking you a series of questions about yourself. Please answer the questions as completely and honestly as possible. If at any time you do not feel comfortable answering a question, you do not have to answer it. You may discontinue the survey at any time. Your responses will remain completely confidential. By participating in this discussion, you understand that your responses may be used in the research study being performed. Thank you.

1. How old are you? _____

2. Note Race: _____

3. Note Gender:_____

4. In what county do you live? _____

5. What is the highest level of education you have completed? _____

6. How much money do you alone earn per year, before taxes? _____

7. What type(s) of insurance do you have?
   HMO ___
   Private ___
   Medicare ___
   Medicaid ___
   Some other form of government assistance ___
   None ___
   Other _____(please state)

8. Who do you live with? Alone___
   With spouse ___
   With family member ___
   With an unrelated individual ___

9. The last time you went to see a healthcare provider, what did you go for?
   Routine Check-Up ___
   Screening (Blood Pressure, Cholesterol, Mammogram, Pap Smear, Prostate Screening, etc.) ___
   Emergency (Heart Attack, Stroke, Fall, etc.)
   To obtain a prescription ___
   Other _____(please state)

10. When is the last time you went to see a healthcare provider? Within the last week ___
    Within the last month ___
    Within the last 3 months ___
    Within the last 6 months ___
    Within the last 9 months ___
    Within the last year ___
    Over a year ago ___

11. Where do you mostly obtain healthcare? Primary Care Physician____
    Hospital___
    Clinic___
    Other___

12a. Does your regular family physician practice in the county in which you reside? Yes ___ No ___
12b. If you answered "No", please state the county in which they are located: _____

13. Is your primary care physician male or female? _____

For the next group of questions I will be asking you about how well you communicate with your healthcare provider. When I use the term healthcare provider I am referring to anyone you might see for a medical visit such as the doctor, nurse, a nurse practitioner, physician assistants, and so on. For the next group of questions please respond on a scale of 1 to 5 where 1 means that you strongly disagree with the statement read to you and 5 means that you strongly agree with the statement read to you.

14. My healthcare provider interrupts me during office visits.

1 2 3 4 5

15. I do not ask questions at medical visits because I do not think I will get a straightforward answer.

1 2 3 4 5

16. My healthcare provider uses medical terminology or technical words that I do not understand.

1 2 3 4 5

17. My healthcare provider spends enough time with me at medical visits.

1 2 3 4 5

18. It is difficult for me to understand my healthcare provider due to his/her accent.

1 2 3 4 5

19. I have the opportunity to finish explaining all of my concerns during office visits.

1 2 3 4 5

20. If I am informed that I have a certain condition, I try to learn about its treatment, symptoms, etc.

1 2 3 4 5

21. My healthcare provider speaks to me as if I am a person and not an object.

1 2 3 4 5

22. My healthcare provider would not tell me if my symptoms meant I had a serious disorder.

1 2 3 4 5

23. When someone goes with me to a medical visit, the healthcare provider(s) speak just to him/her, leaving me out of the conversation.

1 2 3 4 5

24. I feel that my healthcare provider doesn't want to treat me.

1 2 3 4 5

25. My healthcare provider uses overly simple explanations when speaking with me.

1 2 3 4 5

26. My healthcare provider rushes me through medical visits.

1 2 3 4 5

27. I feel anxious or nervous at medical visits.

1 2 3 4 5

28. I seek healthcare because I fear I may have a serious disorder.

1 2 3 4 5

29. I do not ask questions at medical visits because I do not want to insult the healthcare provider.

1 2 3 4 5

30. It is difficult for me to hear my healthcare provider.

1 2 3 4 5

31. I communicate well with my healthcare provider.

1 2 3 4 5

32. When it comes to healthcare, rather than take part in the decision making process, I prefer to just comply with doctor's orders.

1 2 3 4 5

33. I can get reliable health information from healthcare providers other than my physician.

1 2 3 4 5

34. The medical and technological changes that have occurred in my lifetime have left me confused.

1 2 3 4 5

35. I do not ask questions at medical visits because I do not want to bother the healthcare provider.

1 2 3 4 5

OPEN ENDED QUESTIONS

36. What are the biggest communication barriers you have with your health care providers?

37. What sorts of things make a good healthcare provider?

38. Have you every refused to see a healthcare provider again? If so, why?

39. Are there any additional comments that you would like to share with me at this time?

Table 1: Demographic Characteristics

Variable	n	%
Age (x=77.39, SD=6.63)		
65-74 years old	19	32.2
75-84 years old	33	55.9
85 years old and older	7	11.9
Ethnicity		
Caucasian	53	89.8
African-American	6	10.2
Gender		
Female	43	72.9
Male	16	27.1
County of Residence		
Allen	7	11.9
Barren	13	22.0
Hart	7	11.9
Logan	9	15.3
Monroe	18	30.5

Simpson	4	6.8
Trigg*	1	1.7
Educational Attainment		
8th grade or less	25	42.4
9th – 11th grade	8	13.6
High School Graduate/GED	11	18.6
Some College	7	11.9
College Graduate	5	8.5
Graduate School	3	5.1
Yearly Income (x=12593.88, SD=8861.03)		
≤$4999	2	3.4
$5000-9999	16	27.1
$10000-19999	11	18.6
≥$20000	5	8.5
Who Participant Lives With		
Alone	45	76.3
With spouse	12	20.3
With family other than spouse	2	3.4

Table 2: Health Related Information

Variable	n	%
Type of Health Insurance		
Government Program	37	62.7
Private and Government Program	20	33.9
Private Program	2	3.4
Where Participant Mostly Obtains Healthcare		
Primary Care Physician	49	83.1
Hospital	4	6.8
Clinic	5	8.5
Other	1	1.7
Does regular family physician practice in the county in which participant resides?		
Yes	45	78.9
No	11	19.3
Practicing County of Regular Family Physician		
Warren	5	45.5
Barren	3	27.3
Hart	2	18.2
Monroe	1	1.7
Gender of Regular Family Physician		
Male	43	78.2
Female	11	20.0
Reason Patient Last Saw a Health Care Provider		
Prevention	27	45.8
Treatment	32	54.2
Last Time Patient Saw a Health Care Provider		
Within the last week	10	16.9
Within the last month	21	35.6
Within the last 3 months	12	20.3
Within the last 6 months	7	11.9
Within the last 9 months	3	5.1
Within the last year	2	3.4

Table 3: Barriers to Communication

Item	n	%
My health care provider interrupts me during office visits. (x=1.49, SD=.63)		
Agree	26	44.1
Disagree	33	55.9
I do not ask questions at medical visits because I do not think I will get a straightforward answer. (x=1.60, SD=.75)		
Agree	29	50.0
Disagree	29	50.0
My health care provider uses medical terminology or technical words that I do not understand. (x=1.92, SD=.99)		
Agree	36	61.0
Disagree	23	39.0
My health care provider spends enough time with me at medical visits. (x=4.24, SD=.92)		
Agree	26	44.1
Disagree	32	55.9
It is difficult for me to understand my health care provider due to his/her accent. (x=1.53, SD=.68)		
Agree	26	44.1
Disagree	33	55.9
I have the opportunity to finish explaining all of my concerns during office visits. (x=4.19, SD=.82)		
Agree	22	37.3
Disagree	37	62.7
If I am informed that I have a certain condition, I try to learn about its treatment, symptoms, etc. (x=4.24, SD=.86)		
Agree	25	42.4
Disagree	33	57.6
My health care provider speaks to me as if I am a person and not an object. (x=4.44, SD=.57)		
Agree	28	47.5
Disagree	31	52.5
My health care provider would not tell me if my symptoms meant I had a serious disorder. (x=1.95, SD=1.00)		
Agree	35	60.3
Disagree	23	39.7
When someone goes with me to a medical visit, the health care provider speaks just to him/her, leaving me out of the conversation. (x=1.52, SD=.55)		
Agree	23	50.0
Disagree	23	50.0
I feel that my health care provider doesn't want to treat me. (1.53, SD=.54)		
Agree	30	50.8

Disagree	29	49.2
My health care provider uses overly simple explanations when speaking with me. (x=2.22, SD=4.02)		
Agree	6	10.2
Disagree	53	89.8
My health care provider rushes me through medical visits. (x=1.80, SD=.83)		
Agree	35	59.3
Disagree	24	40.7
I feel anxious or nervous at medical visits. (x=2.51, SD=1.25)		
Agree	24	40.7
Disagree	35	59.3
I seek health care because I fear I may have a serious disorder. (x=1.97, SD=1.08)		
Agree	36	61.0
Disagree	23	39.0
I do not ask questions at medical visits because I do not want to insult the health care provider. (x=1.59, SD=.67)		
Agree	28	47.5
Disagree	31	52.5
It is difficult for me to hear my health care provider. (x=1.90, SD=1.06)		
Agree	34	42.4
Disagree	25	57.6
I communicate well with my health care provider. (x=4.34, SD=.60)		
Agree	24	40.7
Disagree	35	59.3
When it comes to health care, rather than take part in the decision making process, I prefer to just comply with doctor's orders. (x=3.59, SD=1.22)		
Agree	41	69.5
Disagree	18	30.5
I can get reliable health information from health care providers other than my physician. (x=3.03, SD=1.39)		
Agree	29	49.2
Disagree	30	50.8
The medical and technological changes that have occurred in my lifetime have left me confused. (x=2.20, SD=.98)		
Agree	15	25.5
Disagree	44	74.5
I do not ask questions at medical visits because I do not want to bother the health care provider. (x=1.64, SD=.74)		
Agree	32	54.2
Disagree	27	45.8